Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3420HOS	A. BUILDING _____ B. WING _____	08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY HOSPITAL	5400 SOUTH RAINBOW BLVD LAS VEGAS, NV 89118

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a focused survey and complaint investigation survey conducted at your facility on 07/30/08 through 08/01/08. The facility is licensed for 210 beds. The state licensure survey was conducted in accordance with Chapter 449, Hospitals, adopted by the State Board of Health December 11, 1998 last amended September 27, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following 17 complaints were investigated. CPT# 16313 Substantiated (Tags S0327, S0328, S0329) CPT# 16151 Substantiated (Tag S0310) CPT# 16176 Substantiated (Tag S0310) CPT# 18695 Substantiated without deficiencies CPT# 16160 Substantiated without deficiencies CPT# 16115 Substantiated without deficiencies CPT# 17492 Unsubstantiated CPT# 15364 Unsubstantiated CPT# 17605 Unsubstantiated CPT# 18274 Unsubstantiated CPT# 18441 Unsubstantiated CPT#15823 Unsubstantiated CPT# 16366 Unsubstantiated CPT# 16070 Unsubstantiated CPT# 18732 Unsubstantiated CPT# 17593 Unsubstantiated CPT# 17264 Unsubstantiated	S 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 000	Continued From page 1 The following regulatory deficiencies were identified.	S 000		
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate care to patients with decubiti ulcers for 2 of 18 patients (#15, #16). Findings include: Patient #15 Record Review: Patient #15 was admitted on 8/23/07 due to altered level of consciousness secondary to syncope with additional diagnoses of Hypertension, Diabetes Mellitus II, End Stage Renal Disease on hemodialysis, Dementia, Hyperlipidemia, history of Cerebrovascular Disease, Carotid Endarterectomy, history of decubitus ulcers and Peripheral Vascular Disease. Record review on 7/30/08 indicated an admission assessment was performed by a licensed vocational nurse (LVN) on 8/23/07. The admission assessment indicated, " ulcer on right heel was present on admission to this hospital. Periwound location is eschared. Wound on left	S 310		

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S 310	Continued From page 2 lateral foot was present on admission to this hospital. Ulcer on left heel was present on admission to this hospital". The left foot with lateral wound was traced on EZ graph wound assessment system and measured "3 centimeters x 4 centimeters, not stageable". The right heel was traced on to the EZ graph wound assessment system, "not stageable", there were no documented measurements. There was no evidence the wound to the left heel was traced on the EZ graph wound assessment system. Three photographs were found affixed to a progress record sheet labeled, "Left heel, Right Heel, and Left Foot (lateral), did not contain a date when the photographs were taken. Review of the hospital's Policy and Procedure page 1 on wound care indicated, "If there is a pressure ulcer present, it must be staged and wound care treatment initiated". Assessment and Reassessment Plan on page 11 indicated, "At the time of admission, each patient will have their needs assessed by a registered nurse (RN). Reassessment will be performed by an RN". An undated Interdisciplinary Care Plan: Skin Integrity was found to have addressed wound care, however, it did not contain directions on how to care for Resident #15's decubiti ulcers. The care plan stated, "Assess and chart skin integrity every 12 hours; Do wound care/dressing change as ordered". The section to describe wound care was left blank. The section for patient teaching was left blank.	S 310		

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S 310	Continued From page 3 Record review of the hospital's Policy and Procedure for unstageable wounds on 7/30/08 revealed, "If the wound base is covered with eschar no stage can be determined; Cleanse with normal saline or wound cleanser. Loosely pack the wound bed with gauze and cover with a dressing. Physician order is required for enzymatic debrider. May require surgical intervention for debridement". No admitting orders were received nor obtained from the admitting physician for wound care on the day of Resident #15's day of admission. This was confirmed by Employee #4 on 7/30/08 at 2:30 PM. Record review revealed, on 8/24/07 at 7:50 AM, a registered nurse documented on the Med-Surg Shift Assessment, "Skin integrity: abrasion. Integrity described as: heal sores on the left heel of the foot, sore on the right foot. Dressings applied to both heels dry and intact". Review of the physician's order dated 8/24/07, lacked documented evidence of any wound treatment orders. This was confirmed by Employee #4 on 7/30/08 at 2:30 PM. On 8/25/07 at 1:32 AM, a Registered Nurse documented on the Med-Surg Shift Assessment, "Skin integrity: abrasion, and blisters. Integrity described as: left heel blister and right heel abrasion". On 8/25/07 at 9:37 AM, a Registered Nurse documented on the Med-Surg Shift Assessment, "Skin integrity: abrasion, and blisters. Integrity described as: bilateral heels. There is no evidence of abuse and/or neglect".	S 310		

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S 310	Continued From page 4 On 8/25/07 at 7:47 PM, Resident #15 was transferred to skilled nursing facility with transfer orders for "wound care evaluation and treatment per protocol; decubitus prevention and care per protocol". Interview with Employee #4 on 7/30/08 at 2:30 PM revealed, a Registered Nurse should have reviewed the patient's admission assessment and should have notified the admitting physician about Patient #15's decubiti ulcers to bilateral heels. Patient #16 Record Review: Patient #16 was admitted to the facility on 12/13/07. Patient #16 was admitted through the emergency department due to left hip pain secondary to fracture to the area. Admitting diagnoses include history of left hip nailing in March 2007, Hypertension, Coronary Artery Disease, Peripheral Vascular Disease, and Atrial Fibrillation. Review of the Emergency Nursing Record dated 12/13/07 at 12:41 PM revealed, Patient #16's skin was intact. Review of the Emergency Physician Record dated 12/13/07 at 12:50 PM indicated, Patient #16's skin color was normal, no rash, warm and dry. Review of the Admission Assessment performed by a Registered Nurse on 12/13/07 at 7:58 PM revealed, Patient #16's integumentary was within the normal limits, as evidenced by skin integrity was intact; Tissues showed no evidence of	S 310		

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S 310	Continued From page 5 redness, inflammation, rashes, ulcerations or wounds. Review of a Registered Nurse's Med-Surg Shift Assessment dated 12/14/07 at 8:00 AM revealed, a pressure ulcer to the left lower leg was reported. A dressing was in place, noted to be clean, dry and intact. Review of a Registered Nurse's Med-Surg Shift Assessment dated 12/16/07 at 8:00 AM indicated, Patient #16 had redness to buttocks. Skin integrity indicated Patient #16 had a skin tear to the left lower extremity. A Physician's Progress note dated 12/17/07 indicated, Patient #16 had undergone surgery on 12/17/07 for a removal of the left hip hardware and insertion of a new hardware. Review of a Registered Nurse's Med-Surg Shift Assessment dated 12/17/07 at 11:17 PM revealed, Patient #16 was on bedrest and was not able to reposition self. Patient #16 was to be turned every 2 hours and required positional support. Patient #16 was unable to ambulate. Range of motion was performed to left upper extremity, right lower extremity and right upper extremity. Patient #16 was on prophylaxis for deep vein thrombosis and was on anticoagulant, and sequential compression device. Left lower leg was elevated on pillows due to hip surgery and pain with movement. Review of the EZ graph Wound Assessment System dated 12/17/07 revealed, Patient #16 had a Stage 3 wound to the left lower leg. The wound was a dry healing ulcer with pink granulation. The wound was traced on the EZ graph, however, the measurements were not documented.	S 310		

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S 310	Continued From page 6 Review of a Registered Nurse's shift assessment dated 12/18/07 at 7:59 AM indicated, Patient #16 had an incision to the left hip. Ulcer to the left lower leg, Stage 3 was present on admission. The ulcer on the left lower leg was not noted in Patient #16's admission assessment. A progress record sheet was found to have two photographs of the left leg affixed to it. The photographs were dated 12/19/07. No measurements were documented. Review of the Interdisciplinary Care Plan on Skin Integrity dated 12/19/07 revealed, Patient #16's skin integrity needed to be assessed every 12 hours. Wound care/dressing change to be provided as ordered. There was no description nor indication on how wound care was to be provided. A progress record sheet was found to have two photographs affixed to the sheet. The photograph on the top was not labeled. The photograph below it was marked, "Stage 2 1 x 1 centimeters" dated on 12/29/07 at 12 noon. There was no indication of the wound location. Another photograph of a wound was also found in a separate progress record sheet without a date, time, location, nor measurements of the wound. A sticker was affixed to the photograph with Patient #16's name, date of birth, gender, medical record number and admission date. Review of a physician's order dated 12/30/07 revealed, a Tegaderm Hydrocolloid was to be applied to Patient #16's sacral area and as needed, DuoDerm to the left foot to be applied	S 310		

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S 310	Continued From page 7 and as needed. No previous physician's orders were found in the chart to address Patient #16's multiple skin breakdown. Review of a physician's order dated 12/31/07 indicated, an air mattress was ordered for Stage 2 decubitus. There was no indication of the decubitus location. Review of a physician's discharge summary dated 1/5/08 revealed, Patient #16 was discharged to a skilled nursing facility with a Stage 2 decubitus ulcer. Severity: 2 Scope: 1 Complaint #16176 Complaint #16151	S 310		
S 327 SS=D	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (b) A provision that requires the initiation of the use of the physical restraints by a registered nurse or other authorized person according to hospital policyach calendar day This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure a thorough assessment of a patient was conducted by a registered nurse, prior to the use of a physical restraint. (Patient #2) Findings include: A Hospital Emergency Nursing Record, dated	S 327		

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S 327	Continued From page 8 09/12/07 indicated Patient #2 was admitted for evaluation of Bleeding Body Sores. The record indicated under neuro assessment that the patient was alert and orientated to person, place and time. On 07/31/08, a review of Patient #2s medical record indicated there was no documentation of a physicians order for restraints or notification of the physician within 12 hours after the use of physical restraints. There was no documentation of a registered nurse assessment justifying the initiation or continued use of physical restraints on Patient # 2. There was no documentation of a restraint flow sheet located in the medical record. The Hospitals Restraint Policy, dated April 2008 indicated restraints were initiated based on an order from a physician. The registered nurse may initiate a restraint in an emergency situation based on an appropriate assessment of the patient. The registered nurse must perform a face to face evaluation of the patient within one hour of initiation of the restraint. The registered nurse will notify the physician as soon as possible regarding the initiation of the restraint and a telephone order or written order must be obtained within twelve hours and entered into the medical record. Patients placed in restraints were monitored a minimum of every two hours and observations were documented on a restraint flow sheet. On 10/18/07 LPN #1 provided an interview with the Hospital. Licensed Practical Nurse (LPN) #1 reported on 9/14/07 he was assigned to take care of Patient #2. LPN #1 indicated he saw Patient #2 fully dressed and ambulating down the hallway with an unsteady gait. LPN #1 described Patient #2s orientation level as orientated to person and place but not to time.	S 327		

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S 327	Continued From page 9 LPN #1 assisted Patient #2 into a wheelchair and transported her back to her hospital room. The patient refused to get back into her bed. LPN #1 reported he transferred Patient #2 to her bed and applied a Posey vest restraint to prevent the patient from falling. LPN #1 then went to the nursing station and informed the charge nurse of the situation and restraint use. LPN #1 reported he did know a physicians order must be obtained within twelve hours after applying restraints to a patient. LPN #1 did not recall if a nursing assessment was done on Patient #2 or if a physician order was obtained for the restraint use. On 07/31/08 at 9:00 AM, the Director of Risk Management reported that on 09/14/07 licensed practical nurse (LPN) #1 assisted in stopping Patient # 2 from walking out of the facility due to her unsteady gait and fall risk. The Director indicated LPN #1 assisted Patient #2 to a wheelchair and transported her back to her room where the LPN transferred the patient from the wheelchair to the bed. LPN #1 then placed a Posey vest restraint on Patient #2 to prevent her from getting out of bed and falling. The Director acknowledged no physician order was obtained for the use of restraints and no registered nurse assessment was completed on the patient prior to the initiation of restraints or after the restraints were applied. The Director acknowledged no restraint flow sheet or restraint documentation was entered into the patients medical record. The Director acknowledged the facilities restraint policies and procedures were not followed in regards to Patient #2s incident. Severity: 2 Scope: 1 Complaint # 16313	S 327		

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S 328 SS=D	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (c) A provision for notifying the physician within 12 hours after the use of the physical restraints is initiated This Regulation is not met as evidenced by: Based on interview, document review and record review the facility failed to ensure a physicians order was obtained within 12 hours after the use of a physical restraint was initiated. (Patient #2) Findings include: The Hospital Emergency Nursing Record, dated 09/12/07 indicated Patient #2 was admitted for evaluation of Bleeding Body Sores. The record indicated under neuro assessment that the patient was alert and orientated to person, place and time. On 07/31/08, a review of Patient #2s medical record indicated there was no documentation of a physician order for restraints or notification of the physician within 12 hours after the use of physical restraints. The Hospitals Restraint Policy, dated April 2008 indicated restraints were initiated based on an order from a physician. The registered nurse may initiate a restraint in an emergency situation based on an appropriate assessment of the patient. The registered nurse must perform a face to face evaluation of the patient within one hour of initiation of the restraint. The registered nurse will notify the physician as soon as possible regarding the initiation of the restraint and a telephone order or written order must be obtained within twelve hours and entered into the medical record.	S 328		

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S 328	Continued From page 11 Patients placed in restraints were monitored a minimum of every two hours and observations were documented on a restraint flow sheet. On 10/18/07 LPN #1 provided an interview with the Hospital. LPN #1 reported on 9/14/07 he was assigned to take care of Patient #2. LPN #1 indicated he saw Patient #2 fully dressed and ambulating down the hallway with an unsteady gait. LPN #1 assisted Patient #2 into a wheelchair and transported her back to her hospital room. The patient refused to get back into her bed. LPN #1 reported he transferred Patient #2 to her bed and applied a Posey vest restraint to prevent the patient from falling. LPN #1 then went to the nursing station and informed the charge nurse of the situation and restraint use. LPN #1 reported he did know that a physicians order must be obtained within twelve after applying restraints to a patient. LPN #1 did not recall if a nursing assessment was done on Patient #2 or if a physicians order was obtained for the restraint use. On 07/31/08 at 9:00 AM, the Director of Risk Management reported that on 09/14/07 licensed practical nurse (LPN) #1 assisted in stopping Patient # 2 from walking out of the facility due to her unsteady gait and fall risk. The Director indicated LPN #1 assisted Patient #2 to a wheelchair and transported the patient back to her room where the LPN transferred the patient from the wheelchair to the bed. LPN #1 then placed a Posey vest restraint on Patient #2 to prevent her from getting out of bed and falling. The Director acknowledged no physician order was obtained for the use of restraints and no registered nurses assessment was completed on the patient prior to the initiation of restraints or after the restraints were applied. The Director	S 328		

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S 328	Continued From page 12 acknowledged that the facilities restraint policies and procedures were not followed in regards to Patient #2s incident. Severity: 2 Scope: 1 Complaint # 16313	S 328		
S 329 SS=D	NAC 449.3628 Physical Restraint Use 6. If the use of physical restraints is permitted pursuant to approved protocols, the approved protocols must include: (d) A requirement that a verbal or written order of the physician be obtained and entered into the medical record of the patient This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure that a verbal or written physicians order for restraints was obtained and entered into the medical record. (Patient #2) Findings include: On 07/31/08, a review of Patient #2s medical record indicated there was no documentation that a physicians verbal or written order for restraints was obtained and entered into the medical record. The Hospitals Restraint Policy, dated April 08 indicated restraints were initiated based on an order from a physician. The registered nurse may initiate a restraint in an emergency situation based on an appropriate assessment of the patient. The registered nurse must perform a face to face evaluation of the patient within one hour of initiation of the restraint. The registered nurse will notify the physician as soon as possible regarding	S 329		

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S 329	Continued From page 13 the initiation of the restraint and a telephone order or written order must be obtained within twelve hours and entered into the medical record. Patients placed in restraints were monitored a minimum of every two hours and observations were documented on a restraint flow sheet. On 10/18/07 LPN #1 provided an interview with the Hospital. LPN #1 reported on 9/14/07 he was assigned to take care of Patient #2. LPN #1 indicated he saw Patient #2 fully dressed and ambulating down the hallway with an unsteady gait. LPN #1 assisted Patient #2 into a wheelchair and transported her back to her hospital room. The patient refused to get back into her bed. LPN #1 reported he transferred Patient #2 to her bed and applied a Posey vest restraint to prevent the patient from falling. LPN #1 then went to the nursing station and informed the charge nurse of the situation and restraint use. LPN #1 reported he did know that a physicians order must be obtained within twelve after applying restraints to a patient. LPN #1 did not recall if a nursing assessment was done on Patient #2 or if a physician order was obtained for the restraint use. On 07/31/08 at 9:00 AM, the Director of Risk Management reported that on 09/14/07 Licensed Practical Nurse (LPN) #1 assisted in stopping Patient # 2 from walking out of the facility due to her unsteady gait and fall risk. The Director indicated LPN #1 assisted Patient #2 to a wheelchair and transported the patient back to her room where the LPN transferred the patient from the wheelchair to the bed. LPN #1 then placed a Posey vest restraint on Patient #2 to prevent her from getting out of bed and falling. The Director acknowledged no physician order was obtained for the use of restraints and no	S 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS3420HOS	A. BUILDING _____ B. WING _____	08/01/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 329	Continued From page 14 registered nurses assessment was completed on the patient prior to the initiation of restraints or after the restraints were applied. The Director acknowledged that the facilities restraint policies and procedures were not followed in regards to Patient #2s incident. Severity: 2 Scope: 1 Complaint # 16313	S 329		